MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
June 19, 2014, 9:30 am to 3:00 pm
Polk County River Place, Room 1
2309 Euclid Avenue, Des Moines, IA
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Thomas Bouska
Neil Broderick
Thomas Broeker
Richard Crouch
Jill Davisson
Marsha Edgington
Representative Dave Heaton
Kathryn Johnson
Betty King (by phone)
Sharon Lambert (by phone)
Geoffrey Lauer
Rebecca Peterson
Michael Polich
Deb Schildroth
Patrick Schmitz
Marilyn Seemann
Suzanne Watson

MHDS COMMISSION MEMBERS ABSENT:

Senator Joni Ernst
Lynn Grobe
Senator Jack Hatch
Representative Lisa Heddens
Brett McLain

OTHER ATTENDEES:

Bob Bacon	U of Iowa, Center for Disabilities and Development
Julie Bak	Mid-Iowa Behavioral Health Region
Jess Benson	Legislative Services Agency
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI Greater DM
Eileen Creager	Aging Resources of Central Iowa
Diane Diamond	DHS, Targeted Case Management
Marissa Eyanson	Easter Seals
Connie Fanselow	MHDS, Community Services & Planning/CDD
Jim Friberg	Department of Inspections and Appeals
Chris Gammell	NAMI of Greater Des Moines
Jennifer Harbison	DHS Policy Advisor
Melissa Havig	Magellan Health Services
Dave Higdon	Polk County Health Services
Karen Hyatt	MHDS, Community Services & Planning
Brandi Jenson	Brain Injury Association of Iowa
Julie Jetter (phone)	MHDS, Community Services & Planning
Ginger Kozak	MHDS, Community Services & Planning
Carrie Malone	House Republican Staff
Jeanette Minor	NAMI Volunteer
John Pollak	Legislative Services Agency

OTHER ATTENDEES (continued):

Cheri Reisner (phone)	MHDS, Community Services & Planning
Joe Sample (phone)	Iowa Department on Aging
Rick Shults	MHDS Division Administrator
Deb Eckerman Slack	ISAC, County Case Management Services

WELCOME AND CALL TO ORDER

Patrick Schmitz called the meeting to order at 9:35 a.m. and led introductions. Quorum was established with fourteen members present and two participating by phone. No conflicts of interest were identified for this meeting.

APPROVAL OF MINUTES

Deb Schildroth made a motion to approve the minute of the May 21 and 22, 2014 meetings as presented. Richard Crouch seconded the motion. The motion passed unanimously, with Betty King and Sharon Lambert voting by phone.

ADMINISTRATIVE RULES FOR CRISIS SERVICES

Karen Hyatt presented an overview of the administrative rules for crisis stabilization services, pointing out that this rules package represents the quality control standards for the accreditation of crisis services in Iowa. The intent today is for the Commission to vote on whether or not to notice the rules. If they are approved, they will be published in mid-July, and will come back again for the Commission to review and approve after the public comment period.

Karen said that SAMHSA (Substance Abuse and Mental Health Services Administration) has created a new crisis services list serve and has been presenting webinars on crisis response. She noted that the states they have used as good examples were states Iowa communicated with and used to model some of the concepts in these rules.

Karen reviewed the structure and format:

Definitions – Twenty-eight new definitions were added for concepts not already defined in Chapter 24. These rules will become a new division (Division II) within the chapter.

Organizational Standards – The beginning of the document lays out "umbrella" standards for all crisis response services. Standards to be met by providers of crisis response services in the areas of policies and procedures and organizational activities reference those already in Chapter 24 for providing other types of services. Each standard has specific performance benchmarks and performance indicators. This area includes safety, accessibility, and protection of individual rights.

Staff Requirements – This section lists the general qualifications for people who could be involved in the delivery of services. Later in the document, there are more specific staff qualifications for each service. For staff other than mental health professionals, some additional mental health training is required. It is intended to be broad enough to work in any area of the State.

Representative Dave Heaton asked what was envisioned in terms of regions having flexibility in meeting staffing requirements and putting together teams. Karen responded that changes in language were made because of those kind of concerns, for example in mobile response, two people are required for safety, yet one can be an EMT (Emergency Medical Technician) or a law enforcement officer to provide more flexibility in staffing. Patrick Schmitz noted that the inclusion of peer support and family support workers also creates more flexibility.

Karen said there are also requirements to track data such as minutes from dispatch to response because we know that will look different in rural and urban areas and that will provide information that can be used to improve the system and target resources where they are needed most. Patrick noted that this list is all of the folks who can comprise the team; that does not mean they are all required for any one service. Each service specifies the minimum staff qualifications for that service.

Service Standards – This section sets the standard for eligibility, which is quite broad: "An eligible recipient is an individual experiencing a mental health crisis or emergency where a mental health crisis screening is needed to determine the appropriate level of care." Standards for confidentiality and legal status, service systems, and respect for individual rights refer back to existing provisions in Chapter 24.

Accreditation – Karen explained a little about how the accreditation process works. Providers are reviewed using the standards and a point process to score how well they meet the indicators. Depending on the score (the percentage of indicators met), providers are accredited for a period of 3 years, 1 year, or a probational period of 6 months. The rules include a chart showing the number of indicators for each service and their weighted value based on a 100-point scale. Patrick Schmitz noted that this is a familiar process to current Chapter 24 providers. Karen added that providers can also be granted deemed status if they are accredited by a recognized national accrediting body. The sections on Complaint Process, Appeal Procedures, and Exceptions to Policy all refer back to existing provisions of Chapter 24.

Standards for individual services – This section indicates that services to children and youth will include coordination with the family and other systems serving the young person, and that services will be responsive to the needs of individuals with co-occurring and multi-occurring conditions.

Question: Is the term "neuro-developmental disability" used on page 13 defined?
Answer: It is not defined in the rules.

Comment: This does not seem to be a recognized term. The term "neuro-developmental disorder" is defined in the DSM-V.

Crisis evaluation – Crisis evaluation includes two components: screening and assessment. Crisis screening is for the safety of the individual and staff members, and to determine the appropriate care or referral for the person in crisis. A consistent and reliable screening process is important to identify the presenting issues and guide people to the most appropriate and least restrictive services. Agencies can determine which staff members do screening; people can be screened at different points in the process. Crisis assessment is a more formal process and includes more gathering more detailed information about the individual, as well as development of an action plan. Assessments must be completed by mental health professionals.

24 Hour Crisis Response – This area is challenging to describe and set standards. It is similar to the emergency services currently defined in Chapter 24. It is a more general type of response capability that revolves around having access to screening at any time of the day or night, and access to information on where to go or how to get appropriate services.

24 Hour Crisis Line – There are crisis lines operating in the State. One of them has gone through the emergency service accreditation process. This service involves screening, triage, and assisting callers in determining the best and most appropriate level or care or support needed. Crisis lines will be required to use standardized software so that data can be tracked and used for quality assurance purposes. Within two years, crisis lines will have to meet the accreditation standards of the American Association of Suicidology with a level one or two rating. That will allow them time to reach those standards. Currently operating crisis lines can be utilized if they meet these standards.

Question: Does the requirement to use standardized call center software mean that all calls will be recorded?
Answer: Not necessarily. The system would have that capability, but recording calls is not required. That could be a provider decision.

Question: Can you be specific about the difference between 24 hour crisis response and a 24 hour crisis line? They seem very similar.
Answer: The counseling people would receive on a 24 hour crisis line would be in the nature of peer counseling; the 24 hour crisis response would involve more assistance in access to services and helping people know where to go in the system.

Question: Why did you choose the accreditation standards of the American Association of Suicidology?
Answer: Other entities that accredit crisis lines, have a strong information and referral component (for example, AIRS (Alliance of Information and Referral Systems)); for this purpose providers would not necessarily need to meet those I & R standards.

Warm line – A warm line looks different than a crisis (or "hot") line. It provides non-judgmental listening and nondirective assistance. There are various examples nationwide. Some models are peer support run and peer staffed and some offer peer counseling. The rules do not reflect any expectation for the number of hours a warm line would be available. That is flexible. Existing warm lines around the country vary greatly in hours of operation; they are usually limited hours. The high priority hours are usually evening and until around 2:00 a.m. They are often staffed by a mixture of paid workers and trained volunteers. Iowa Concern is an example of a statewide warm line service; they also work closely with the 911 system when calls need emergency referral.

Question: Should there be a foundational number of hours they would have to operate?
Answer: There is currently no minimum number of hours required in these rules.

Question: There is not any eligibility shown for specific disability groups; should that be stated?
Answer: That was intentional. The standard for eligibility is "an individual experiencing a mental health crisis or emergency where a mental health crisis screening is needed to determine the appropriate level of care." There are no diagnostic criteria for the provision of services.

Mobile Response – This service is intentionally called mobile response, not mobile response teams, to build in flexibility. It is the provisions of onsite, in-person intervention for individuals who are experiencing a mental health crisis. Crisis staff is directed to respond in pairs to ensure the safety of the individual as well as their own safety. To allow more flexibility in rural areas or other areas where staffing levels may be a concern, one staff member may respond in tandem with a trained member of law enforcement or an emergency medical technician.

Question: Would law enforcement personnel or EMTs be trained?
Answer: There are steps in place for LEOs and EMTs to receive MHFA (Mental Health First Aid) as minimum training. That is an 8-hour training and certification, which is the minimum training referenced in the rules.

Question: What about references to "department approved training"? What does that mean?
Answer: That is yet to be determined. It allows providers to acquire or develop their own training and submit it to the Department for approval. It will not be a finite list. Competency can be demonstrated by pre-training and post-training tests. Certification may or may not be attached.

Question: In my area of the state, when there is a mental health crisis, two police respond – will that practice continue?
Answer: If that is the local practice, law enforcement could continue to respond in the same way. The emphasis under these rules is to create a response model that includes one or more trained person who understands mental illness.

Question: Will there be consequences if an organization cannot meet the response times?
Answer: The value placed on those indicators is not enough to preclude a provider from continuing to provide that service based on longer response times. The Department is aware that the times are ambitious and has a commitment to using the data gathered on response times to identify where additional resources may be needed.

23 Hour Crisis Observation and Holding – Twenty-three hours means less than a full day. This service is designed for individuals who need short-term crisis intervention in a safe environment that is less intensive and less restrictive than hospitalization. You will note that the standards for this and the next two services are a lot more detailed than the earlier services discussed. These services involve more intense intervention and the need to ensure a safe and appropriate environment for the person.

Question: Why 23 hours? Why "holding?"
Answer: The reason for the time limit is based on hospital admission criteria; longer changes the character of the services and could place providers in a new licensing category. "Holding" is a term that came from the language in the legislation.

Question: Is there a requirement for direct observation of the person? Is that needed for safety?
Answer: These rules do not specify the level of direct observation. Any concerns about that as a safety issue could be addressed through comments.

Crisis Stabilization Community Based Services (CSCBS) – These services are designed to provide a safe, secure environment that is less intensive and less restrictive than hospitalization. The goal of CSCBS is to stabilize and re-integrate the individual back into the community. It is to be provided in the individual's own home or apartment, or in some other community-based setting, and should look different from a residential service.

Representative Heaton commented that providers may be unwilling to accept the risk of serving individuals that are more challenging, and work should be done to determine how providers can be supported to take those risks. He said that would help address the problem of having people continuing to occupy acute care beds longer than necessary because they have nowhere else to go. Rick Shults noted that the Department of Inspections and Appeals has developed rules for subacute care and has been seeking comments on them. DHS is working with DIA to make sure that they efforts of both agencies come together.

Crisis Stabilization Residential Services (CSRS) – This service has many similarities to CSCBS, but is delivered in a group residential or facility-type setting. It is designed for individuals who need a safe, secure environment that is less intensive and less restrictive than inpatient hospitalization. The goal of CSRS is to stabilize and re-integrate the individual back into the community. The program need to have the capacity to serve more than two individuals at the same time and can have no more

than 16 beds. The average stay is expected to be 3 to 5 days. The rules specify that the program must be staffed 24 hours a day and staff must be awake at all times.

Question: Have you considered that the availability of a licensed person for consultation 24 hours a day will be difficult to meet?
Answer: That is the reason that telehealth is included as an option. There are growing options for providing telehealth through video conferencing that are affordable.

Patrick Schmitz commented that his agency has eight pieces of telehealth equipment in their programs and they are used every day. Kathy Johnson added that the Abbe Center also routinely uses telehealth in serving rural areas.

Question: There is a requirement for people using CSCBS to have contact with a mental health professional at least once a day; is that reasonable with the limited availability of mental health professionals?
Answer: We believe it is. The definition of mental health professional includes Master's level practitioners, and they should have reasonable availability.

Question: Is five days average for other similar programs?
Answer: Three to five days is standard for this type of service. Length of stay is one of the pieces of data that will be tracked.

Question: What happens if the crisis is not stabilized in three to five days? If people have to leave the program because of a time limit, they may just go back into crisis.
Answer: We recognize that there will be exceptions and the rules include a provision that allows the provider to document reasons that a length of stay beyond 3 to 5 days is needed.

Dave Higdon commented that he would encourage extending the period for up to 30, 60, or even 90 days. He said Polk County is planning to do that with their crisis stabilization services because they think it will decrease the churn to more expensive services.

Deb Schildroth commented that the transitional living program at Mary Greeley in Ames also allows more time when needed for evaluation, planning, and ensuring that the person has been able to get to where they need to be to live successfully in the community again.

Patrick Schmitz commented that at some point, that may be a different service from crisis stabilization that the person needs to transition to as a next step. Rick Shults said that one of the areas DHS has tried to tackle is how to make it clear that different services can be provided in the same location. A person's mental health crisis may be resolved, and now there is a need for transitional housing; it is possible for one provider can do both in a seamless way that meets the individual's needs.

Medication Administration, Storage and Documentation – These provisions apply to 23 hour crisis observation and holding, crisis stabilization community-based services, and crisis stabilization residential services.

Question: Does crisis stabilization mean all of these services or just some of them? Will they be standard across the regions?
Answer: All of the services described in these rules fall under the general category of crisis stabilization. Some of them are included in core services and some of them fall under the additional or "core plus" services. These rules are intended to allow regions to identify a crisis response delivery model that makes sense for their area and includes most or all of the services.

Suzanne Watson said she thinks these rules give regions and providers choices in determining how to serve their communities. Some agencies may provide just one piece or several services, and there is an opportunity to build to a point of consistency across the State.

Representative Heaton asked if funds from the Medicaid offset could be reinvested in services of this type or other specific areas at the Director's recommendation. Rick Shults said that the Director is charged with putting recommendations in the DHS budget for the use of money that has gone into the property tax relief fund. He said that basic crisis response is part of core services, and is, generally, what community mental health centers are already doing. Most of the enhanced services that go beyond 24-hour access to crisis response would be additional. Rick noted that there are also opportunities for regions to work together to provide some services.

Rick said that these rules represent a shift from the rules that have been written recently related to the operation of regions, including those that define core and core plus services. These rules have a different approach because they serve as the accreditation standards for providers. Different entities may provide services; each provider has to meet the requirements for the particular services they want to provide. Suzanne Watson said that she thinks all the regions are working on some core plus services and want to develop comprehensive services to improve the system.

Motion & Vote - Geoff Lauer made a motion to adopt the administrative rules as presented by filing the notice of intended action, pending approval of the Administrative Rules Review Committee. Jill Davisson seconded the motion. The motion passed 14 to 0. Sharon Lambert and Betty King were not on the phone for the vote.

Rick Shults thanked everyone who has worked on the rules, noting that many people have been involved and have invested many hours in developing a detailed and complex rules package.

DHS/MHDS UPDATE

Rick Shults updated the Commission on MHDS and DHS activities. He noted that Theresa Armstrong is on her way back from a policy development activity in Washington, D.C. with others from the Department of Corrections and community mental health centers. Their work is related to improving and coordinating the delivery of health services for people being released from prison. Rick said the agencies are in the process of streamlining and focusing on eligibility requirements for prisoners who may qualify for the Iowa Health and Wellness Plan.

Regions - Regions have been working diligently on getting the documents in place for them to be operational on July 1. That includes 28E agreements, policy and procedures manuals, budgets, and draft transition plans. They are pulling their governance groups together. DHS has been meeting with regional leads and talking with them about the process. In response to a question, Rick confirmed that when the regional plans have been approved by the Department they will be posted on the DHS website.

Medicaid Offset – The Iowa Health and Wellness Plan was authorized by the 2013 legislature; the same legislation also identified the process for determining the offset amount. That language was revised during the 2014 legislative session, so the calculation has changed somewhat. First, any offset that can be paid from equalization funds by January 1 would go into the Property Tax Relief Fund (PTRF). Rick noted that the fund name seems to indicate it is for property tax relief, but it is not. Money in the PTRF is available to the legislature to appropriate for regional mental health and disability services. The Department is to include recommendation in its budget request for how that money should be used.

Where a county does not receive equalization funds, or the funds received are not sufficient to cover the offset, the county will have to lower its property tax levy by a like amount in the next fiscal year. Those fundamental pieces that we have talked about before did not change. The money that goes into the Property Tax Relief Fund is then available for the legislature to appropriate for mental health and disability regional services and the legislature added language saying that the Department is to make recommendations in its budget request about how those funds should be used.

There are still three “pots” of money:

- 20% is kept by the counties/regions
- The amount that is paid by equalization goes to property tax relief fund
- Where equalization does not sufficient counties will lower their property taxes by that amount in 2016

The substance of that section did not change; what did change was the calculation. The new calculation for the offset is 80% of:

- The cost of the first six months (from July 1, 2013 to December 31, 2014) of specific services provided to a specific group of people who would be eligible for IHAWP

- Minus the cost for the same group of services and people for the 6-month period from January 1, 2014 to June 30, 2014.
- Multiplied by two to get an annualized number

Rick said the Department is still meeting with regions to come to an agreement on the specific service codes and the designation of the group of people to be used in the calculation. They will be getting together again by phone tomorrow to make some final decisions to move forward. Rick said that counties have their own ways of identifying, tracking, and coding payments that are not the same as those used by Medicaid. It is likely that the Commission will be seeing some administrative rules related to the offset process in the near future.

Suzanne Watson commented that the Medicaid offset language still refers to county data rather than regional and that could lead to issues between counties. She said that as levy rates change and counties are not all at the same rate, it could become more challenging for then to continue working together around financial issues.

Legislative Actions

Workgroups - The Department has been directed in legislation to carry out two workgroup activities:

- To bring together a group of people to talk about the challenges in creating a comprehensive community support system for people with mental illness. This will probably involve revisiting some of the topics discussed in redesign, re-evaluating where things are at now, identifying strengths and barriers, and providing a report to the legislature by December 15.
- To partner with Iowa Vocational Rehabilitation Services (IVRS) to form a workgroup on increasing vocational opportunities for people with mental health conditions and disabilities. The legislature appropriated funds for IVRS to draw down more federal dollars for this purpose.

Rick noted that Commission members will probably be asked to participate in the workgroups.

Funding - The Governor has taken his final action on legislation. He approved the funds to address the HCBS Waiver waiting lists. He vetoed the one time spending bill, which included funding for the hospital bed tracking system and for electronic health records for community mental health centers and substance abuse providers. Funds for compensatory education for the students at the Iowa Juvenile Home were also vetoed as a part of that bill; even so, the educational services are continuing and DHS will find funding to keep those services going. The funding for construction at Broadlawns Hospital was not vetoed.

Cost Settlement - The bill to allow community mental health centers to opt out of cost reporting and go to an alternative reimbursement rate methodology was approved. Magellan has already implemented the steps necessary to make that happen.

Integrated Health Homes – Phase 2 started in April, and the third phase for IHHs will begin on July 1. The 69 remaining counties will be added and there will be statewide access to IHHs. Commission members expressed interest in having a presentation from Magellan in August or September to provide an update on IHH implementation.

IHAWP – Enrollment continues to grow well ahead of the forecasted numbers. Over 103,000 Iowans are enrolled out of an estimated group of about 150,000. About half of the enrollees were previously served through the Iowa Cares program. There is a lag time built into the medically exempt process and those numbers are not yet where they should be. It has been estimated that there should be 15,000 people or more in Iowa who could benefit from the medically exempt program and the current number enrolled is between five and six thousand. Most of the folks applying in the beginning were self-identified; now most are being referred by providers.

Rick explained that the medical exempt process is intended to identify people in the IHAWP groups who have chronic physical or mental illnesses, or disability-related needs and move them into the Medicaid State Plan, which provides greater access to the specific kinds of enhanced services they need. Rick said he urges everyone to share information about that process so that people who may qualify will apply. The Department is working on identifying people from claims data and that process is proving helpful. Magellan has been working with IME to notify people who are identified as potentially eligible.

PUBLIC COMMENT - No public comment was offered.

A break was taken for lunch at noon.

The meeting resumed at 1:10 p.m. Sharon Lambert was on the phone for the afternoon session.

REVIEW OF TASKS AND COMMITTEES

Patrick Schmitz reviewed the duties and tasks for the committee sessions. Connie Fanselow shared copies of the previous three biennial reports filed by the Commission in January of 2009, 2011, and 2013, and a preliminary list of some of the reports and resources available as a starting point for the groups. The members broke into committee groups from about 1:20 to 2:00 p.m.

SMALL GROUP COMMITTEE MEETINGS

County/Regional Services Committee members Deb Schildroth, Richard Crouch, Rebecca Peterson, Tom Bouska, Geoff Lauer, Kathy Johnson, and Sharon Lambert (by phone) met to discuss how to evaluate the extent to which services to persons with disabilities are actually available to persons in each county in the state and the quality of those services. Committee member Patrick Schmitz met with the Cost Increase Committee.

MHI and SRC Committee members Marsha Edgington, Neil Broderick, Marilyn Seemann, and Suzanne Watson met to discuss how to evaluate the effectiveness of the services being provided by disability service providers in this state and by each of the state mental health institutes established under chapter 226 and by each of the state resource centers established under chapter 222. Committee member Brett McLain was absent.

Cost Increase and Communications Committee members Patrick Schmitz, Tom Broeker, Michael Polich, and Jill Davisson met to discuss how to advise the Director on determining an amount to include in his budget that should be appropriated to the Mental Health and Disability Regional Services fund for the succeeding fiscal year to address the increase in the costs of providing services. Committee members Deb Schildroth and Rebecca Peterson met with County/Regional Services group, and Betty King was not able to participate by phone.

Patrick Schmitz called the meeting back to order at 2:00 p.m.

COMMITTEE REPORTS

Each committee reported on their discussions and identified resources or information they would like to review in preparation for their biennial report.

Cost Increase Committee – Jill Davisson reported for the Committee:

- Would like to look at Medicaid cost report information for the last couple of years
- Will research inflation indices
- Continue to ask legislature to leave property tax levy rates at status quo for a while longer

MHI and SRC Committee – Suzanne Watson reported for the Committee:

- SRC Barriers Report
- DHS goals for MHIs and SRCs (budget narrative)
- Data/Report from Money Follows the Person initiative
- List of admission criteria for MHIs
- Waiting list information for SRCs and MHIs (number and length of wait)

County/Regional Services Committee – Deb Schildroth reported for the Committee:

- Outcomes Redesign Workgroup Report
- Outcomes listed in SF 2315
- IDPH state plan for brain injury and needs assessment for brain injury
- Outcomes for brain injury from IDPH
- Information on out of state placements
- Information on Autism Support Program
- Regional services plans
- Report on co-occurring capability (Minkoff and Cline work; how many people/agencies have been trained?)

- Homeless population – how are they being identified or linked to mental health services?
- How many children are receiving mental health services in school? Information from Department of Education?
- How many children are being served by PMICs? Information on discharge planning and transition back to home communities?
- Services available to youth aging out of foster care?
- Services available to prisoners being released?
- Information on the availability of telehealth? Is there Magellan claims data?
- Information on cultural competency and accessibility? Check with Department of Human Rights?
- Information on enrollment in integrated health homes
- Information on enrollment in IHAWP and medical exemption process

Connie Fanselow will work with MHDS staff to gather information and MHDS will report back on the status of these requests at the July meeting.

NEXT MEETING

The next meeting is scheduled for Thursday, July 17 at ChildServe, 5406 Merle Hay Road, Johnston.

PUBLIC COMMENT - No public comment was offered.

The meeting was adjourned at 2:15 p.m.

Minutes respectfully submitted by Connie B. Fanselow.